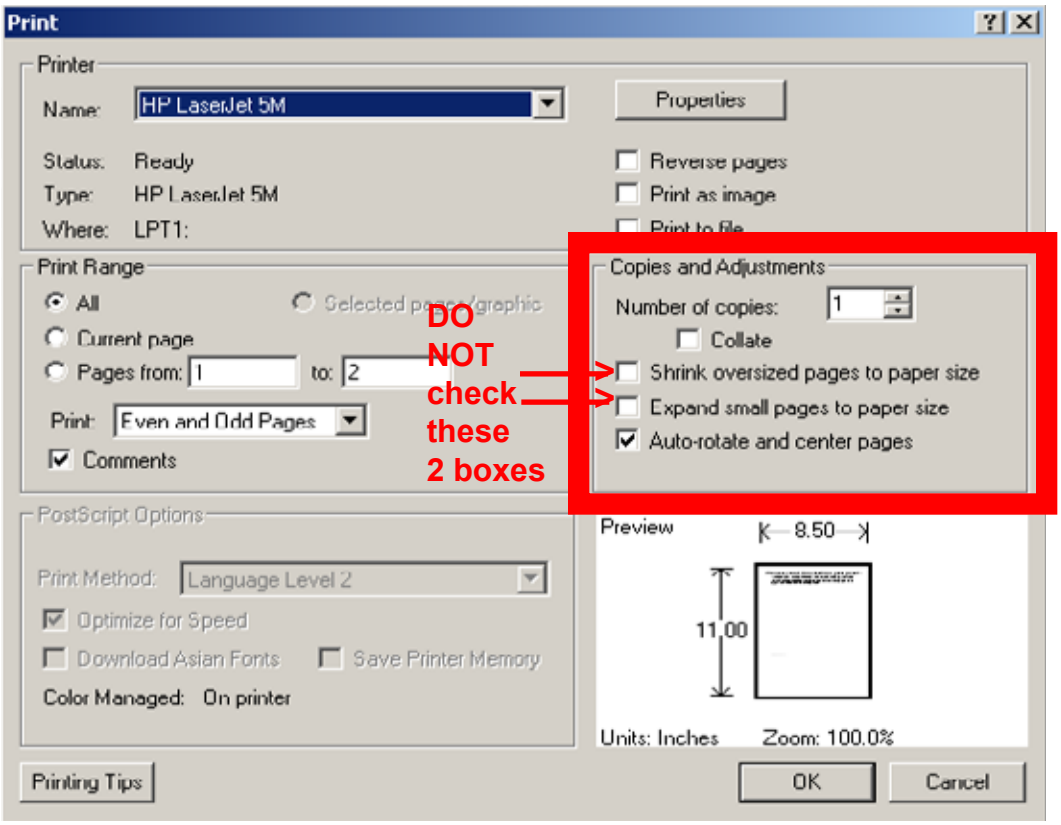
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



DOH 600-033 (3/2006)

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Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Registered Nurse (Foreign Training) Application Packet

1. 669-233 ... Contents List/SSN Information/Deposit Slip ..... 1 page
2. 669-234 ... Instructions for Registered Nurse Educated Outside the United States, NCLEX, HIV-AIDs Information ..... 3 pages
3. 669-002 ... Application for License Activation by Examination or Endorsement ..... 4 pages
4. 669-057 ... Certification of Nursing Education..... 1 page
5. 669-020 ... Verification of Licensure from Country Outside of U.S.A. ..... 1 page
6. 669-218 ... Verification of Licensure From U.S. State of Original Licensure ..... 2 pages
7. Nur*sys* License Verification Request Instructions and Form ..... 2 pages

B. Important Social Security Number Information:

*Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.

*Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Registered Nurse (Foreign Training)

DEPOSIT SLIP

NAME (Please Print) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$ _____

☐ **Check**
☐ **Money Order**

DOH 669-233 (REV 3/2006)

1F 0258010000 00099

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Washington State Department of Health
Washington State Nursing Commission
P.O. Box 1099
Olympia, WA 98507-1099

Instructions for the Registered Nurse Educated Outside The United States

Please read: WAC 246-840-050
WAC 246-840-080

Effective May 1, 1981, all applicants from countries outside the United States, and never before licensed in one of the United States jurisdictions, shall have passed the Commission on Graduates of Foreign Trained Nursing Schools (CGFNS) qualifying examination.

To apply for the CGFNS, please contact them at:

Commission on Graduates of Foreign Nursing Schools
3624 Market Street
Philadelphia, PA 19104
(215) 349-8767

CGFNS will provide you with information regarding exam dates, fees, and sites. A certificate is awarded by CGFNS on successful completion of the examination. **You WILL NOT be eligible for the NCLEX-RN until you have passed the CGFNS and our office receives verification of your certificate DIRECTLY from CGFNS.**

Instructions For Completion Of The Application For NCLEX-RN

If you were licensed by endorsement in a U.S. jurisdiction from a foreign country after 12-31-71, you must take and pass NCLEX prior to becoming licensed in this state. Call (360) 236-4706 for more information.

Washington State Application:

1. Application completed in full
2. Passport size 2”x2” photograph of yourself, taken within the past year. Applicant **must** sign the photograph.
3. CGFNS certificate (from CGFNS) or Verification of RN licensure from original state of licensure in the USA. Have the state complete the verification form and mail directly back to the Nursing Commission office.
4. Verification of Licensure from your country of original licensure must be completed by that country and mailed directly back to the Nursing Commission office.
5. Check or money order made payable to the Department of Health in the amount of $70. This fee is non refundable.
6. Verification of completion of 7 hours HIV/AIDs education requirement.
7. Transcripts from school of nursing.*
8. If you have tested in another US jurisdiction, you must provide us with a copy of your failure letter(s).
9. Mail the application, 2”x2” photo, verification of AIDS education and the $70 fee to:

   Department of Health
   Washington State Nursing Commission
   PO Box 1099
   Olympia, WA 98507-1099

10. It is **very** important to register with the testing company at the same time you are registering with the Nursing Commission.

***Transcripts:**

Your Transcripts **must** be in English and be mailed directly to the Nursing Commission from your school of nursing, your original licensing board, or CGFNS. **They are not valid** if sent by the applicant. Your transcripts of record must show the hours of theory and days in clinical practice in Medical, Surgical, Obstetrics, Nursing of Children (Pediatrics) and Psychiatric Nursing. Please request a course description be mailed with your transcripts directly from your school of nursing.

Time Frames:

Once your application is complete and approved, we will notify the testing company of your eligibility to test. The entire application process takes about 4-6 weeks. **Do not** call in that time period, we **will not** be able to help you.

NCLEX-RN Candidate Bulletin:

Please carefully read and follow the directions in your Candidate Bulletin. Do not throw this away until after you receive your results. The Candidate Bulletin will tell you how to complete the file the registration form with the testing company. **Results are mailed approximately 4 weeks following your examination.** Please refer to your Candidate Bulletin and Scheduling and Taking Your NCLEX booklet for answer to your questions.

Download the NCLEX Examination Candidate Bulletin from their website at www.ncsbn.org.

Failure/Retake:

You will be issued a license upon passing. Should you fail the examination, the Nursing Commission office will mail your results with instructions for retaking the examination. You have four opportunities in a two-year period of time to successfully complete the NCLEX-RN. There is a 91-day wait between examinations.

Canadian Licensees:

If you were originally licensed in Canada in one of the following provinces between the following years, you can be licensed in Washington through endorsement. These provinces had used the SBTPE for RNs during these time periods:

Alberta	1952-1970
British Columbia	1949-1970
Manitoba	1955-1970
Newfoundland	1961-1970
Nova Scotia	1955-1970
Prince Edward Island	1959-1970
Quebec (English speaking)	1959-1970
Saskatchewan	1956-1970

The following documentation is needed for licensure:

1. Verification of licensure from your Province or original license.
2. Certification of your nursing degree/diploma with a copy of your transcripts. This must come from your school of nursing or from a Board of Nursing.
3. Copy of a current/active license.
4. Completed application with $70 fee.
5. Completion of 7 hours of HIV/AIDS education.

Please mail all related materials to the Following address:

Department of Health
Washington State Nursing Commission
P.O. Box 1099
Olympia, WA 98507-1099

Please call (360) 236-4706 if you have questions.

HIV/AIDS Information

AIDS Education Requirements for Health Related Professions

All health related professions under the disciplinary authority of the Uniform Disciplinary Act (RCW 18.130) are affected. This requirement went into effect January, 1989.

The topics that must be covered by this requirement are: *etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality and psychosocial issues to include special population considerations.* The course must be seven (7) hours or more in length.

If you completed your nursing program in 1989 or later and completed this requirement in the nursing courses, or a CE course, etc., after this time, you may complete the attestation portion of your application which specifies you have met this requirement. Keep documentation of completion for future reference. You may need to show proof to an employer.

If you feel you have not met this requirement, or you cannot document that you have, you can meet this requirement through a correspondence course or a community college. A partial listing of available offerings follows:

Robert D. Anderson Publishing Company
1-800-532-2332

Washington State University
Intercollegiate College of Nursing
1-800-281-2589

University of Washington
(206)543-1047

Impact Inc.
(206) 284-3865

Department of Health
AIDS Information Hot Line
1-800-272-2437
Website: www.doh.wa.gov/cfh/hiv.htm Select “prevention”

New York State Nurses Association
(518) 782-9400
E-mail: info@nysna.org
Website: http://www.nysna.org

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Washington State Department of Health

Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY		
LICENSE DATE	CANDIDATE NUMBER	VALIDATION NUMBER
SCHOOL CODE	GRADUATE DATE	

☐ AIDS ☐ Cert ☐ MBOS ☐ Verif (Foreign) ☐ Photo
☐ Scripts ☐ CGFNS ☐ TOEFL ☐ Active License) ☐ Other

LICENSE #

Application For License By Examination Or Endorsement

☐ **Registered Nurse**
☐ Examination ☐ Endorsement

☐ **Licensed Practical Nurse**
☐ Examination ☐ Endorsement

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. All applications must be accompanied by applicable fee which is non-refundable. Photo copied applications are not accepted. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME LAST FIRST MIDDLE INITIAL

MAILING ADDRESS

CITY | STATE | ZIP | COUNTY

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS HOURS**.) ( )

RESIDENCE TELEPHONE ( )

SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 2.23 RCW) — —

GENDER ☐ Male ☐ Female

BIRTHDATE (MO/DAY/YR)

PLACE OF BIRTH (CITY/STATE)

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list

Attach Current Photograph Here. Indicate Date Taken and Sign in Ink Across Bottom of the Photo. **Required for examination only, not endorsement applicants.**
NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

2. Education

High school graduate? ☐ Yes ☐ No

If no, GED? ☐ Yes ☐ No

INSTITUTION	NAME	LOCATION	DATE ENTERED	DATE COMPLETED	DIP/DEGREE GRANTED
COLLEGE OR UNIVERSITY					
COLLEGE OR UNIVERSITY					
COLLEGE OR UNIVERSITY					
COLLEGE OR UNIVERSITY					

3. AIDS Education and Training Attestation

I certify I have completed the minimum of seven (7) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

4. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

   1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

   1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

   (If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The Department does criminal background checks on all applicants.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

   a. the use or distribution of controlled substances or legend drugs? ☐ ☐

   b. a charge of a sex offense? ☐ ☐

   c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

   a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ☐ ☐

   b. committed any act involving moral turpitude, dishonesty or corruption? ☐ ☐

   c. violated any state or federal law or rule regulating the practice of a health care professional? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements. ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ☐ ☐

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? ☐ ☐

5. Previous Licensure

List all states where any health care licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current.

STATE/JURISDICTION	PROFESSION	LICENSE TYPE	LICENSE		METHOD OF LICENSURE
			YEAR ISSUED	NUMBER	

6. Licensure In Other State(s) Or Country(ies)

List all states/countries you have held an RN or an LPN license in. List these licenses in the order they were issued to you (1st, 2nd, 3rd, etc.)

STATE/COUNTRY	CHECK ONE		CURRENT EXPIRATION DATE
	AS RN	AS LPN	

State or **country** in which originally licensed by examination. _____

Year license first issued _____ as an ☐ RN ☐ LPN

Have you taken the State Board Test Pool Examination (SBTPE) or NCLEX in the United States? ☐ Yes ☐ No

If yes, state _____ as an ☐ RN ☐ LPN

Have you ever applied for licensure in Washington prior to this application? ☐ Yes ☐ No

If yes, under the name of _____ as an ☐ RN ☐ LPN Approximate date _____

7. Applicant's Attestation

I, _____, certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

_____ _____
SIGNATURE OF APPLICANT DATE

Official Use Only

Washington State Records Center

Washington State Department of Health

Nursing Commission
P.O. Box 47864
Olympia, WA 98504-7864

Certification Of Nursing Education
From School of Nursing Outside of U.S.A.

Applicant: Complete this section and mail to the school of nursing from which you graduated.

Present Name _____
LAST FIRST MIDDLE MAIDEN

I graduated on _____ from the school of nursing under the name of _____

Date of Birth _____ Social Security Number _____
MONTH DAY YEAR REQUIRED FOR LICENSURE

I hereby request that this certification be completed, a transcript included and mailed to:

Department of Health
Washington Nursing Commission
PO Box 47864
Olympia, WA 98504-7864

Signature of Applicant _____

Address _____

_____

APPLICANT, PLEASE DO NOT WRITE BELOW THIS LINE

To be completed by the chief administrative officer of the school of nursing from which the above named applicant graduated. Please return this form directly to the Washington Nursing Commission.

Recorded Name of Graduate _____

Name of School of Nursing _____

Location _____

School Approved By _____

Date Student Entered _____ Date Course Completed _____

Length of Course _____ Diploma/Degree Received _____

Please attach an official **transcript** (record of all subjects taken, including hours of class and weeks of clinical experience) for this applicant. This document must carry the school seal or stamp and signature of the chief administrative officer.

SCHOOL STAMP OR SEAL

Signature of Chief Administrative Officer _____

Title _____

Date _____

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Washington State Department of Health
Health Professions Quality Assurance
PO Box 47864
Olympia, WA 98504-7864

Verification of Licensure
From Country Outside of U.S.A.

APPLICANT: Complete this section and mail to the Government agency where original licensure was granted.

Present Name _____
LAST FIRST MIDDLE MAIDEN

I hereby request that the verification form below be completed and mailed to:

Department of Health
Washington State Board of Nursing
PO Box 47864
Olympia, WA 98504-7864 U.S.A.

I was registered by your bureau under the name _____

and certificate number _____ dated _____

Signature of Applicant _____

Address _____

_____

APPLICANT: PLEASE DO NOT WRITE BELOW THIS LINE

To be completed by the nurse licensure authority in country where applicant was originally licensed. Please return this form directly to the Washington State Board of Nursing.

Certification Of Licensure

This is to certify that _____ after passing a governmental

examination was granted a certificate of licensure as _____

according to the laws of the country of _____ on _____
COUNTRY DAY MONTH YEAR

The certification was number _____

The license is currently in good standing: ☐ Yes ☐ No

If other basis for licensure (than governmental examination) please explain on the reverse side.

The school of nursing from which the applicant graduated was approved by this government at the time of graduation: ☐ Yes ☐ No

Name of licensing/registration agency _____

(Affix Official Seal Here)

Signature _____

Title _____

Date _____

(This page intentionally left blank.)

Washington State Department of Health
Health Professions Quality Assurance
Nursing Commission
P.O. Box 47864
Olympia, WA 98504-47864

Verification of Licensure From U.S. State of Original Licensure

Please complete the top portion of this form and forward to your **original** state of licensure.
(Please contact your original state of licensure for fee charged and processing time.)

Check One Box: ☐ **Registered Nurse** ☐ **Licensed Practical Nurse**

NAME LAST	FIRST	MIDDLE INITIAL

PREVIOUS LAST NAMES USED	SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 2.23 RCW) — —

CURRENT MAILING ADDRESS

CITY	STATE	ZIP

NAME AS IT APPEARS ON ORIGINAL LICENSE	ORIGINAL STATE OF LICENSURE	CURRENT STATE OF LICENSURE

I hereby authorize the release of my licensure data to the Washington State Nursing Commission.

Signature _____ Date _____

This portion to be completed by **original state** of licensure and mailed to: *Washington State Nursing Commission, PO Box 47864, Olympia, Washington 98504-7864.*

This is to certify that _____ was issued license number _____

on _____ to practice ☐ registered nursing ☐ licensed practical nursing (vocational nursing).

Licensed by: ☐ Exam ☐ Endorsement ☐ Other (specify) _____

Current Licensure Status: ☐ Active ☐ Inactive ☐ Lapsed | EXPIRATION DATE

Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)? ☐ Yes ☐ No (if yes, attach explanation)

Disciplinary action pending? ☐ Yes ☐ No (if yes, attach explanation)

Nursing Education Program Completed:

Location (City & State):

Type of Nursing Program: ☐ Diploma ☐ BSN ☐ ADN ☐ LPN ☐ Other (specify) | DATE OF COMPLETION

Examination Scores: **State Board Test Pool Exam**

	Score	Series
Medical		
Psychiatric		
Obstetric		
Surgical		
Nursing of Child		
LPN/VN		

NCLEX:
RN _____ Series _____
LPN _____ Series _____

NCLEX CAT:
RN _____ Date _____
LPN _____ Date _____

(SEAL)

SIGNATURE	STATE	DATE

State Boards of Nursing

Alabama 334-242-4060

Alaska 907-269-8161

Arizona 602-331-8111

Arkansas 501-686-2700

California 916-322-3350
..... LPN 916-263-7800

Colorado 303-894-2430

Connecticut 860-509-7624
..... 860-509-7607

Delaware 302-739-4522

District of Columbia 202-727-7468

Florida 850-488-0595

Georgia ..... RN 478-204-1640
..... LPN 478-204-1620

Hawaii 808-586-2695

Idaho 208-334-3110

Illinois 312-814-5859

Indiana 317-233-4409

Iowa 515-281-3255

Kansas 786-296-2453

Kentucky 502-329-7000

Louisiana 504-838-5396

Maine ..... 207-287-1133 x 33

Maryland 410-585-1900

Massachusetts 617-727-1631

Michigan 517-373-0930

Minnesota 612-617-2270

Mississippi 601-359-6208

Missouri 573-751-0068

Montana 406-841-2340
..... 406-841-2345

Nebraska 402-471-0317

Nevada ..... Reno 702-786-3135
..... Las Vegas 702-739-5968

New Hampshire 603-271-2323

New Jersey 973-504-6493

New Mexico 505-841-8340
..... 505-841-8345

New York 518-474-3845

North Carolina 919-782-3211

North Dakota 701-328-9777

Ohio 614-466-7834

Oklahoma 405-962-1820

Oregon 503-731-4745

Pennsylvania 717-783-7142

Rhode Island 401-277-2827

South Carolina 803-896-4550

South Dakota 605-362-2765

Tennessee 615-532-9839

Texas 512-305-7400

Utah 801-828-3180

Vermont 802-828-3180

Virginia 804-662-9909

West Virginia 304-558-3596

Wisconsin 608-266-2112

Wyoming 307-777-7121

NCSBN Nursys®
National Council of State Boards of Nursing

FORM INSTRUCTIONS

1. Only boards of nursing within the United States have access to Nur*sys*.® If you need verification of a license for a foreign country or to an agency other than a state board of nursing, please contact your state board of nursing.

2. You **MUST CONTACT** the state where you are seeking licensure to determine which state(s) they require verification from, as boards of nursing have different requirements.

   If you do not need verification of a license from one of the states listed below, **DO NOT** complete this form. Instead, follow the verification instructions of the state where you are seeking licensure. Complete this form **ONLY** if the state where you are seeking licensure requires verification from one of the states listed below.

Alaska (AK)	Kentucky (KY)	New Hampshire (NH)	South Dakota (SD)
Arizona (AZ)	Maine (ME)	New Jersey (NJ)	Tennessee (TN)
Arkansas (AR)	Maryland (MD)	New Mexico (NM)	Texas (TX)
Colorado (CO)	Massachusetts (MA)	North Carolina (NC)	Utah (UT)
Delaware (DE)	Minnesota (MN)	North Dakota (ND)	Vermont (VT)
Florida (FL)	Mississippi (MS)	Ohio (OH)	Virginia (VA)
Idaho (ID)	Missouri (MO)	Oregon (OR)	West Virginia-PN (WV)
Indiana (IN)	Montana (MT)	South Carolina (SC)	Wisconsin (WI)
Iowa (IA)	Nebraska (NE)		

3. Please complete all sections of this form. Forms with missing information or incorrect payments will be returned. **SEND ONLY THIS FORM AND PAYMENT. ALL OTHER FORMS ARE UNACCEPTABLE**.

4. **PAYMENT:** To verify RN licenses, the total fee is $30, regardless of how many states you are licensed in or how many states you are applying to. To verify LPN licenses, the total fee is $30, regardless of how many states you are licensed in or how many states you are applying to. To verify both RN and LPN licenses, the total fee is $60, regardless of how many states you are licensed in or how many states you are applying to.

   All payments must be guaranteed funds. **The only acceptable forms of payment are: certified checks, cashiers checks, or money orders** – made payable to the **NCSBN**. DO NOT SEND cash, personal checks, business checks, credit cards, or traveler's checks. **Fees are non-refundable**.

5. Please complete this form in blue or black ink. Print or type clearly. Illegible forms will be returned.

6. Verifications are entered into Nur*sys*® in the order in which they are received at NCSBN. **The verification report will remain in Nur*sys*® for 90 days, after which it expires.** When the Board of Nursing receives your Endorsement Application, the board will access Nur*sys*® to verify any licenses held in the states listed in number 2 above. No paper reports are sent from NCSBN.

7. **EXPIRED REPORTS:** If your verification has expired, you must pay an additional $30 and submit a new verification request form to NCSBN.

8. Nur*sys*® information is updated monthly from the participating nursing boards listed in number 2 above. A nurse who recently received a license may have to wait until the next update before the information is available in Nur*sys*® for license verification.

9. If you have questions regarding this form, please contact the Nur*sys*® License Verification Department at (312) 525-3780 or toll free (866) 819-1700.

***** NEW ***** Want to process your verification faster? Try our new secure Online Verification to process your verification immediately. Go to **https:\\www.nursys.com**

LICENSE VERIFICATION REQUEST FORM

*** **NEW** *** Want to process your verification faster? Try our new secure Online Verification to process your verification immediately. Go to **https:\\www.nursys.com**

Please use blue or black ink. ***See reverse side for form eligibility and instructions.***

PERSONAL INFORMATION

Social Security Number:	Date of Birth (mm/dd/yyyy)	
First Name:	Middle Name:	Last Name:
Maiden Name:	Date of Original License (mm/yyyy)	
Street Address:		
City:	State:	Zip/Postal Code:
Country:	Home Phone:	Work Phone:

ENDORSEMENT INFORMATION *List the license types that you need verified*

License Type (check one)	Total Verification Fee
LPN: ☐	$30.00
RN: ☐	$30.00
Both LPN & RN: ☐	$60.00

Fees are not refundable

The only acceptable forms of payment are
CERTIFIED CHECK, CASHIER'S CHECK,
or **MONEY ORDER**.
Made payable to: NCSBN
DO NOT SEND cash, personal checks, business checks, or travelers checks.

LICENSE INFORMATION *List all licenses that you have ever had*

	Jurisdiction/State	RN License Number	PN License Number
Original			
Additional			
Additional			
Additional			

State applying to: _____

I, the above named individual, hereby apply for verification to the National Council of State Boards of Nursing to permit the NCSBN and/or its Member Boards to verify my licensure, educational, disciplinary, and related information in Nur*sys*® for the purposes of supporting my request for endorsement verification in the jurisdiction(s) listed above and any other states in which I have ever been licensed. I also confirm that the information I have submitted is true.

My application fee of **$** _____ in **guaranteed funds** is attached.

Mail this form to:
National Council of State Boards of Nursing, Inc.
35331 Eagle Way
Chicago, IL 60678-1353
DO NOT SEND THIS FORM TO YOUR BOARD OF NURSING

Signature _____ Date _____